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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any fee is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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7837
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07829

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			
c. LENGTH OF STAY IN 1b D.O.A.				d. STREET ADDRESS 220 W. Main			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Hilary		First John Middle Balling Last		4. DATE OF DEATH 7 1 1961		Month Day Year	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-7-1912	9. AGE (In years last birthday) 49 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY House Painting		11. BIRTHPLACE (State or foreign country) Del.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John W. Balling				14. MOTHER'S MAIDEN NAME Louise Nurnberg			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		16. SOCIAL SECURITY NO. 217-05-3869		17. INFORMANT Mrs. Marie P. Balling, 220 W. Main St.		Address Elkton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) 920.1						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE R.C. Dodson		EXAMINER'S NAME (Type) R.C. Dodson		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7-2-61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 3, 1961		22c. NAME OF CEMETERY OR CREMATORY Cathedral Cemetery		22d. LOCATION (City, town, or country) (State) Wilmington, Del.	
23. FUNERAL DIRECTOR Ralph E. Hicks		ADDRESS Elkton, Md.		24a. REC'D BY REGISTRAR 10 '61		24b. REGISTRAR'S SIGNATURE Charles S. Kinross	

M

Local

Ms.

Local

Clinton

Local

Clinton

Union Local

200 W. Main

Henry

John

Belling

2-3-1918

Clinton

House Painting

Bel.

Local Numbers

John W. Belling

21-62-3889

Mr. Wm. P. Belling, 200 W. Main St.

Clinton, N.Y.

Local Community Organization

R.C. Nelson

Livingston, N.Y.

1-3-01

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7838
CERTIFICATE OF DEATH
07830

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institutions; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>EIKTON</u>		c. LENGTH OF STAY in lb <u>25 DAYS</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE 12-24-2</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>De VUE HAVEN CONVALESCENT HOME</u>				d. STREET ADDRESS <u>803 REVOLUTION ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>PHOEBE</u> Middle <u>BRENDA</u> Last <u>BRENDA</u>				4. DATE OF DEATH Month <u>7</u> Day <u>30</u> Year <u>1961</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/28/1884</u>	
9. AGE (in years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>30</u>		11. IF UNDER 24 HRS. Hours <u>7</u> Min. <u>30</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>	
13. FATHER'S NAME <u>JOHN ROBINSON</u>				14. MOTHER'S MAIDEN NAME <u>Ida May Urban</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>AOA B. WALLETT- HAVER DE GRACE</u>		17. INFORMANT <u>AOA B. WALLETT- HAVER DE GRACE</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTION LUNGS & VISCERA</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY ARTERIOSCLEROSIS</u> DUE TO (c) <u>PNEUMONITIS</u> INTERVAL BETWEEN ONSET AND DEATH <u>24 HRS.</u> <u>YEARS.</u> <u>7 DAYS.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour <u>19</u> a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/15/61</u> , 19 <u>61</u> , to <u>7/30</u> , 19 <u>61</u> , that (I) <u>(see)</u> last saw the deceased alive on <u>7/30</u> , 19 <u>61</u> , and that death occurred at <u>5:00</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>J. Randall Ross</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7/30/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. RANDALL ROSS, M.D.</u>				22d. ADDRESS <u>EIKTON, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/1/1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>		23d. LOCATION (City, town or county) (State) <u>Haver de Grace Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Clemmings</u>				25a. REC'D BY REGISTRAR <u>Aug 3 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Knead</u>	

(M)

10/2/92

10/2/92

(1)

Handwritten notes and signatures, including dates like 10/2/92 and 10/3/92, and names like "John" and "Mary".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

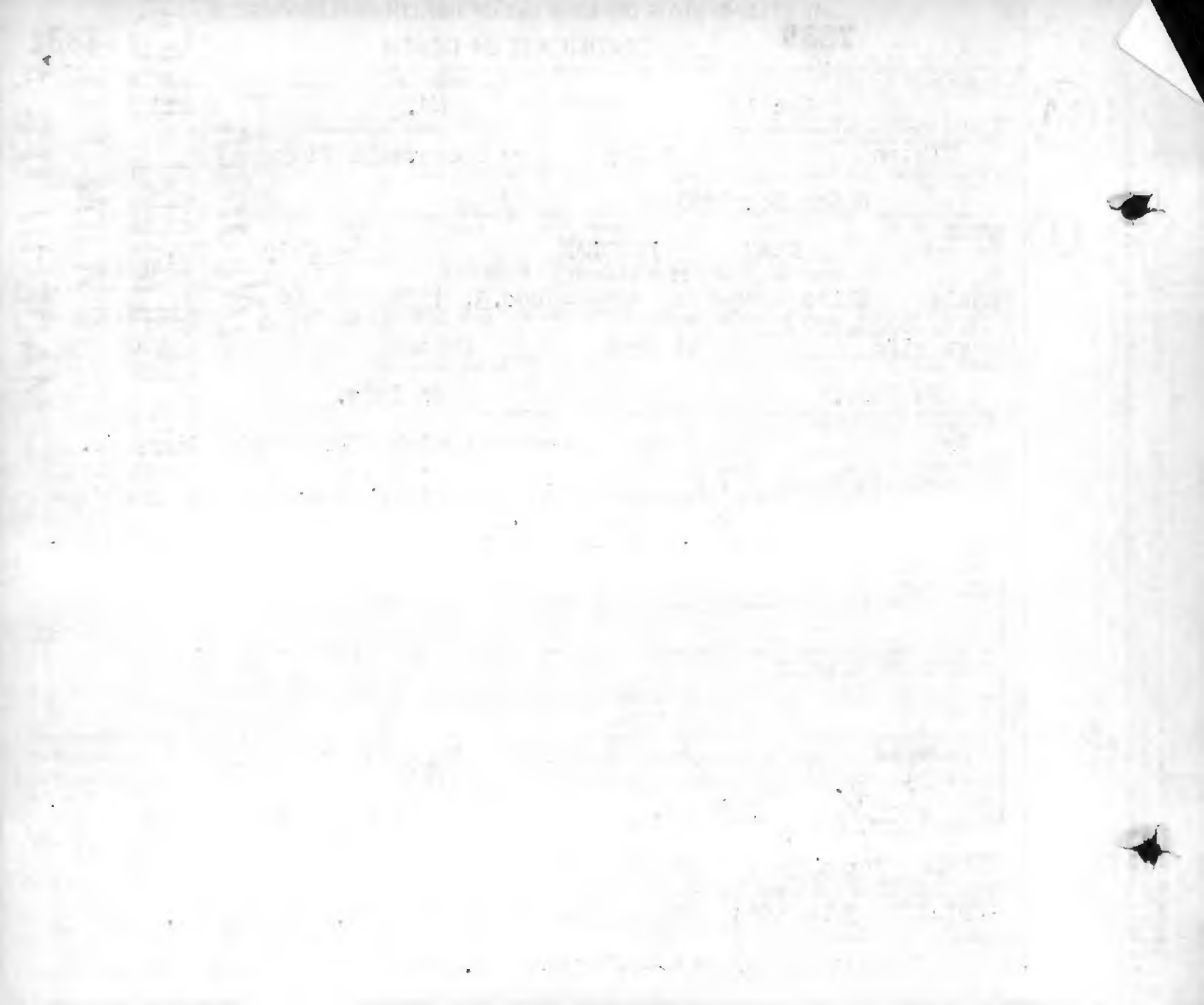
VS A15 (4)
15M 9/58

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7839
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

Reg. Dist. No.

07831

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle BAWULAK Last		4. DATE OF DEATH July 20, 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 3, 1894
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY at Home	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME No Info.		14. MOTHER'S MAIDEN NAME No Info.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Panko Bawulak		Address Chesapeake City, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X DUE TO Cardiovascular disease (b) Diabetes Mellitus (c) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 2 days within	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 17, 1961, to July 20, 1961, that I last saw the deceased alive on July 20, 1961, and that death occurred at 10:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Henry V. Davis M.D.		ADDRESS (Street, city or town, state) CHESAPEAKE CITY DATE SIGNED 7/24/61	
PHYSICIAN'S NAME (Type) HENRY V. DAVIS MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/24/1961	
22c. NAME OF CEMETERY OR CREMATORY Immaculate Conception		22d. LOCATION (City, town, or county) (State) Nr. Elkton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS PIPPIN FUNERAL HOME 1000 N. 2nd St. Elkton, Md.		24a. REC'D BY REGISTRAR DATE JUL 26 '61	
24b. REGISTRAR'S SIGNATURE Arthur L. Thomas			



CERTIFICATE OF DEATH

Reg. Dist. No. 07832

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>New Castle</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middletown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>		d. STREET ADDRESS <u>5 S. Cox St., 46X-3</u>	
3. NAME OF DECEASED (Type or print) First <u>Clifton</u> Middle <u>Thomas</u> Last <u>Beck</u>		4. DATE OF DEATH Month <u>July</u> Day <u>15</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 25, 1884</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Beck</u>		14. MOTHER'S MAIDEN NAME <u>Alice Morries</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs. Clifton Beck</u>		Address <u>Middletown, Del.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO <u>Chronic nephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>burnts</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 30, 1961</u> to <u>July 15, 1961</u> , that I last saw the deceased alive on <u>July 15, 1961</u> , and that death occurred at <u>10:49 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry J. Damm</u> M.D.		ADDRESS (Street, city or town, state) <u>Chesapeake, Md</u>	
DATE SIGNED <u>7/15/61</u>			
PHYSICIAN'S NAME (Type) <u> </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/18/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Massey Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Massey Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>St. Louis Daniels - Middletown, Delaware</u>		24a. REC'D BY REGISTRAR <u> </u>	24b. REGISTRAR'S SIGNATURE <u>Charles E. Hume</u>

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7841

CERTIFICATE OF DEATH

Reg. Dist. No. 07833

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sassafras. 14 X - 2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Pearl Middle Blackiston Last Blackiston				4. DATE OF DEATH Month July Day 26 Year 19 61			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March, 14, 1884	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Chestertown, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME W.L. Faulkner				14. MOTHER'S MAIDEN NAME H.C. Collins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No.		16. SOCIAL SECURITY NO. Informant		Address Mrs. Pearl Jarrell, 2520 West St. Wilm. Del.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC BRAIN SYNDROME 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROSIS GENERAL DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH 2 years.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from July 24, 1961 to July 26, 1961 that I last saw the deceased alive on July 26, 1961 , and that death occurred at 2:40 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Henry V. Davis M.D. PHYSICIAN'S NAME (Type) HENRY V. DAVIS M.D. CHESAPEACE CITY Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July, 29, 1961		22c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		22d. LOCATION (City, town, or county) (State) Chestertown, Kent Co; Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows, Millington, Md.				24a. REC'D BY REGISTRAR DATE JUL 31 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

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1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

7842

CERTIFICATE OF DEATH

Reg. Dist. No. 07834

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE MARYLAND b. COUNTY CECIL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESAPEAKE CITY		c. LENGTH OF STAY IN 1b 3 mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MORGAN NURSING HOME		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANNA Middle ELIZABETH Last BOYLES		4. DATE OF DEATH Month JULY Day 22 Year 1961	
5. SEX F	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT 25 1879
9. AGE (In years last birthday) 81 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME HENRY W. TAYLOR		14. MOTHER'S MAIDEN NAME LETITIA KNOTTS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT WM. RAY BOYLES		Address WARWICK MARYLAND	
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) THX DUE TO Hemiplegia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Hypertension C.V. Disease (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH Months 2 years
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 7			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 6 , 1961, to July 22 , 1961, that I last saw the deceased alive on July 22 , 1961, and that death occurred at 2:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) CHESAPEAKE CITY MD DATE SIGNED 7/22/61			
ACTUAL SIGNATURE Henry V. Davis MD M.D.		PHYSICIAN'S NAME (Type) HENRY V. DAVIS MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 7/25/1961	22c. NAME OF CEMETERY OR CREMATORY WARWICK CEMETERY	22d. LOCATION (City, town, or county) (State) WARWICK MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME		24a. REC'D BY REGISTRAR ELKTON 1961	24b. REGISTRAR'S SIGNATURE Charles S. Kline

1 FOR STATE HEALTH DEPT.

TO D. 77 MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
5M 9/60

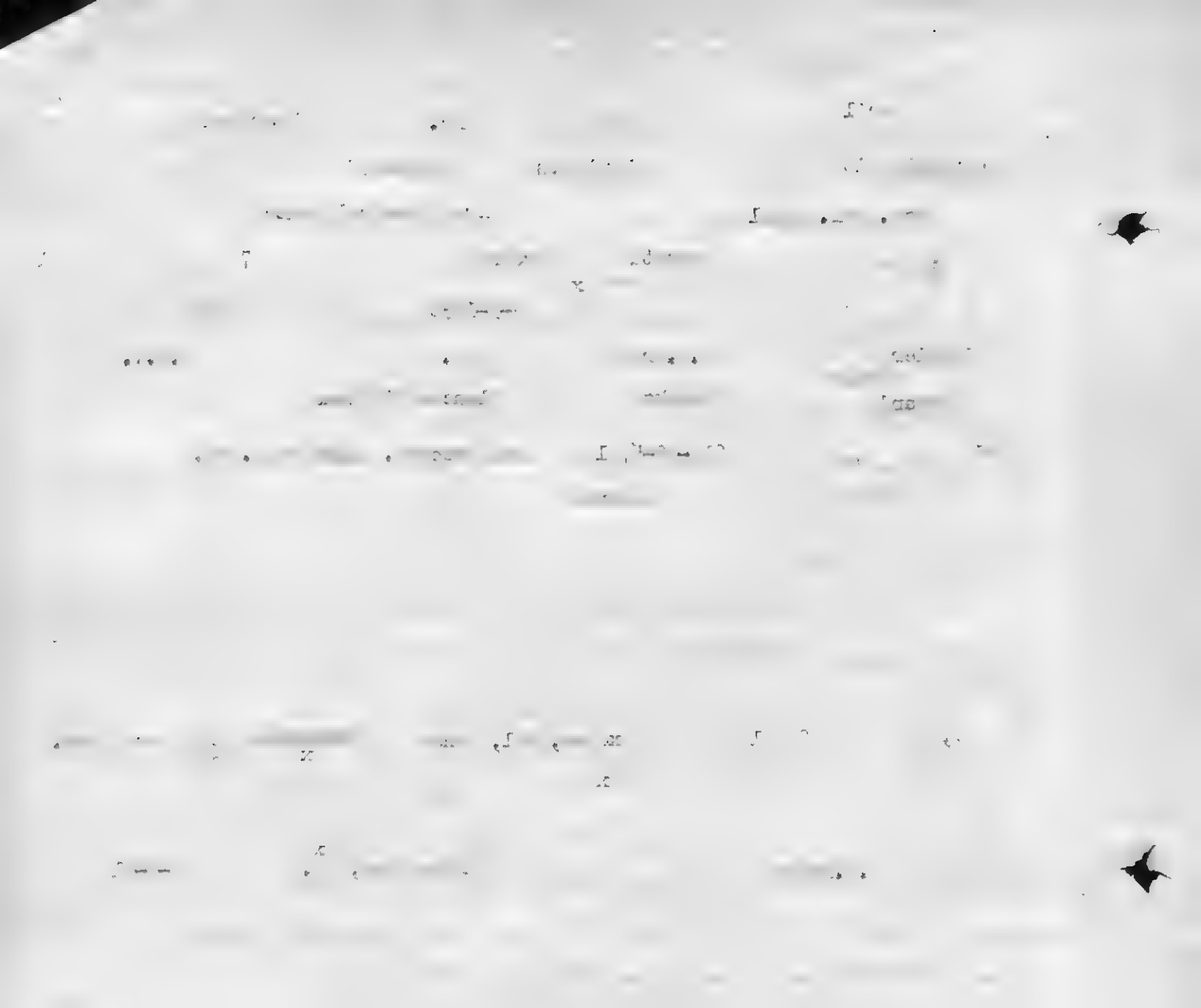
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7843 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0785

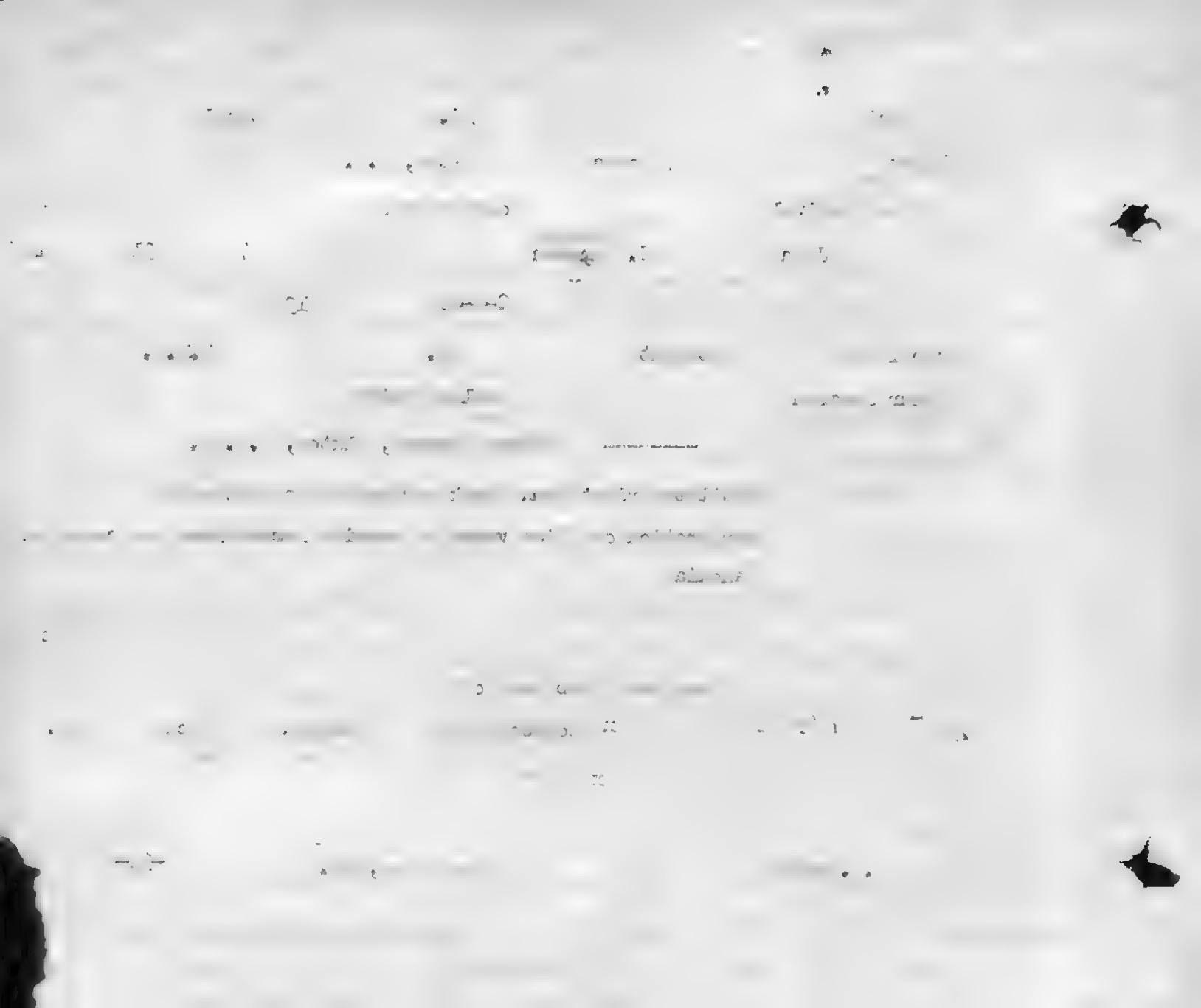
1. PLACE OF DEATH a. COUNTY Cecil		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chesapeake City		c. LENGTH OF STAY IN lb few hours		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md.		b. COUNTY Harford		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood Bel air - Rural		d. STREET ADDRESS Army Chemical Center		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Alfred		First Augustus		Middle Brooks		Last Brooks		4. DATE OF DEATH Month 7		Day 2		Year 19 61			
5. SEX M		6. COLOR OR RACE C		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-5-1936		9. AGE (in years last birthday) 25 yrs.		IF UNDER 1 YEAR Months 25		IF UNDER 24 HRS. Days 25		Hours 25	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier		10b. KIND OF BUSINESS OR INDUSTRY U.S. Army		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME Edward		13. FATHER'S NAME Edward		14. MOTHER'S MAIDEN NAME Blanche Williams		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) yes		16. SOCIAL SECURITY NO. 218-32-5791		17. INFORMANT Army Records. A Edge wood. Md.		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 72908 DUE TO Browned															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) 72908 DUE TO (c)															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Ches. Del. Canal													
20c. TIME OF INJURY Month, Day, Year 7 2 19 61 Hour a.m. 7:30		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Ches. Del. Canal		20f. (City or town) Chesapeake City Cecil Md.		(County)		(State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE R.D. Dodson		EXAMINER'S NAME (Type) R.D. Dodson		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 7-3-61					
22a. BURIAL, CREMATION, or other disposition July 5, 1961		22b. DATE THEREOF July 5, 1961		22c. NAME OF CEMETERY OR CREMATORY Clark's Chapel		22d. LOCATION (City, town, or country) Harford Co Md		(State) Md							
23. FUNERAL DIRECTOR H.S. Bailey		ADDRESS Washington Md		4a. REC'D BY REGISTRAR DAHL 12 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kline									

MEDICAL CERTIFICATION



VS. A15ME
5M 9/60

1. PLACE OF DEATH a. COUNTY Cecil		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY in 1b 47 hours		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Md. b. COUNTY Cecil c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton, R.D. d. STREET ADDRESS Dogwood Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) John		First John		Middle H. D. Cameron		Last Cameron		4. DATE OF DEATH Month 7 Day 31 Year 19 61									
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-9-48		9. AGE (In years last birthday) 13 yrs.		IF UNDER 1 YEAR Months 13 Days 13 Hours 13 Min. 13							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Boy				10b. KIND OF BUSINESS OR INDUSTRY Student				11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Arthur Cameron				14. MOTHER'S MAIDEN NAME Buelah Smith													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no				16. SOCIAL SECURITY NO. -----				17. INFORMANT Arthur Cameron, Elkton, R.D.Md. Address									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mutilated right hand Shock perforation of intestines DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) perforation of Iliac vessels massive hemorrhage and cerebral (c) anoxia												INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Home made bomb went off													
20c. TIME OF INJURY Month, Day, Year 8:50 a.m. 7 29 19 61				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Dogwood Road				20f. (City or town) Elkton		(County) Cecil		(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7-31-61	
ACTUAL SIGNATURE R.C. Dodson				EXAMINER'S NAME (Type) R.C. Dodson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Aug 3, 1961				22c. NAME OF CEMETERY OR CREMATORY Gilpin Manor Mem. Park				22d. LOCATION (City, town, or country) Elkton				(State) Md.	
23. FUNERAL DIRECTOR Ralph E. Hicks				ADDRESS Elkton, Md.				24a. REC'D BY REGISTRAR DATE AUG 14 '61				24b. REGISTRAR'S SIGNATURE Arthur L. Harris					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be filed with the funeral director, and the funeral director should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7845

07836

1 PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City		c. LENGTH OF STAY IN 1b 3 WEEKS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Morgan Nursing Home		d. STREET ADDRESS Rock Hall	
3 NAME OF DECEASED (Type or print) First Middle Last EDNA M. CHILCOAT		4. DATE OF DEATH Month Day Year July 25, 1961 19	
5 SEX FEMALE	6 COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/22/84
9 AGE (in years last birthday) 77 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George		14. MOTHER'S MAIDEN NAME Emma Woodward	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 12-22-2644	
17. INFORMANT Mrs. Charles Gorsuch		Address Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 532X DUE TO Cerebral Thrombosis - Left Hemisphere Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary artery disease (c) unknown		INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Leukemia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from July 13, 1961, to July 25, 1961, that (I) (we) last saw the deceased alive on July 25, 1961, and that death occurred at 8:00 PM from the causes and on the date stated above			
22a. SIGNATURE Henry V. Davis		22b. DATE 7/25/61	
22c. PHYSICIAN'S NAME (Type) HENRY V. DAVIS MD		22d. ADDRESS CHESAPEAKE CITY MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 28, 1961	
23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		23d. LOCATION (City, town, or county) (State) Chestertown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		ADDRESS Chestertown, Md.	
25a. REC'D BY REGISTRAR DATE JUL 28 '61		25b. REGISTRAR'S SIGNATURE William S. Hanna	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar or to burial, cremation, or removal, and in any event within 72 hours after death.

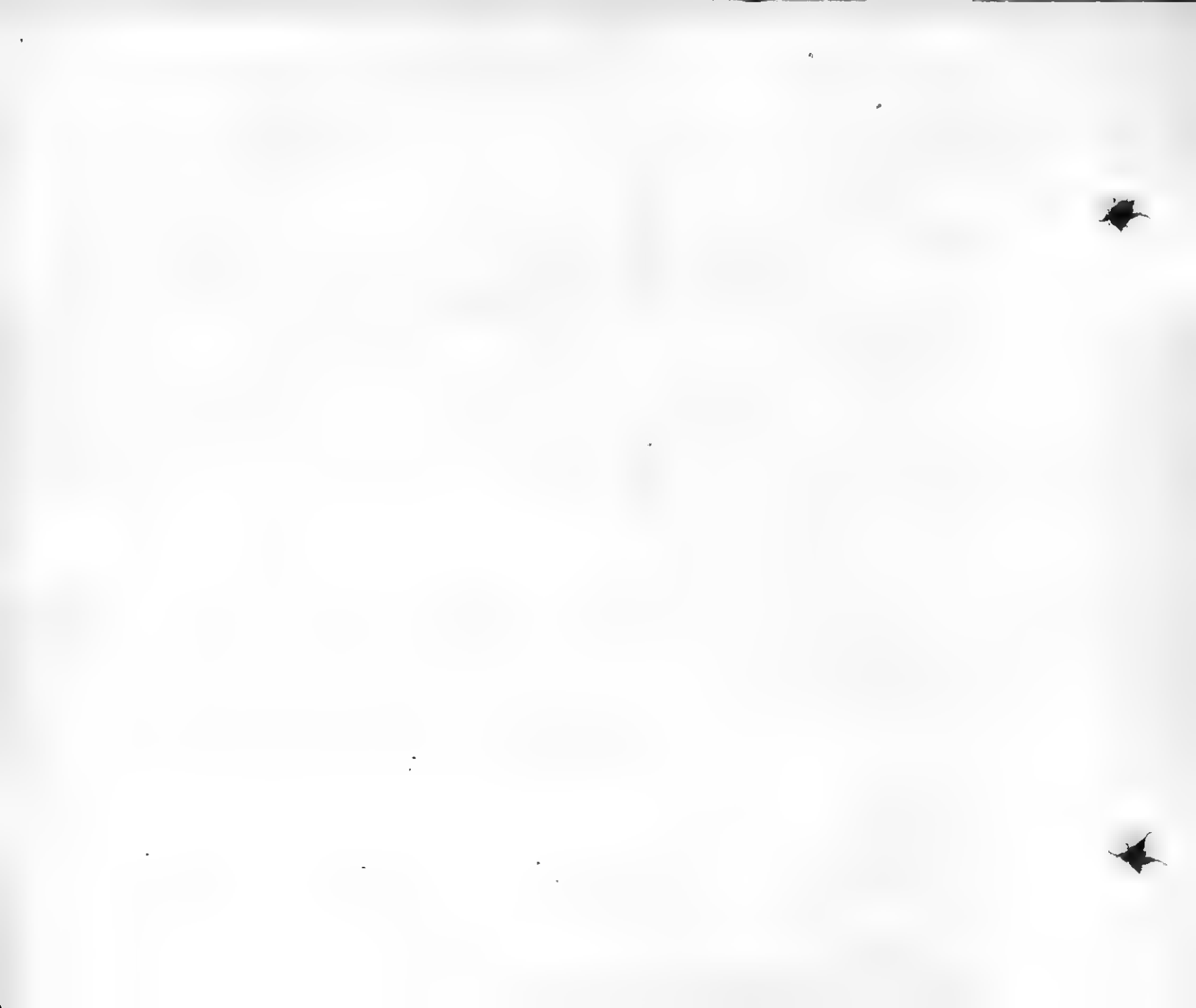
VS A15 (4)
15M 9/58

7846

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 2 filed 7/10/61
CERTIFICATE OF DEATH

Reg. Dist. No. 07837

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institut an Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b X CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bohemia Manor	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		d. STREET ADDRESS near Chesapeake City	
3. NAME OF DECEASED (Type or print) First Middle Last Sadie M. Congo		4. DATE OF DEATH Month Day Year July 4, 19 61	
5 SEX Female	6. COLOR OR RACE Col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 10, 1900
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Mercer		14. MOTHER'S MAIDEN NAME Phomie White	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Thomas Congo-Bohemia Manor, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>multiple sclerosis</u> 345X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 6 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 61		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 29, 1961, to May 4, 1961, that I last saw the deceased alive on May 4, 1961, and that death occurred at 3:00 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Chesapeake City Md.	
ACTUAL SIGNATURE Henry V. Davis M.D.		DATE SIGNED 7/6/61	
PHYSICIAN'S NAME (Type) HENRY V. DAVIS MD		CHESAPEAKE CITY MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/7/61	
22c. NAME OF CEMETERY OR CREMATORY Bohemia Manor Cem.		22d. LOCATION (City, town, or county) (State) Bohemia Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edw. R. Bell		ADDRESS 909 Polar St. Wilmington, Delaware	
24a. REC'D BY REGISTRAR DATE 10/61		24b. REGISTRAR'S SIGNATURE Arthur S. Howard	



may be received by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7847

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

Items 5 & 6 Film G292 8/7/61 iwk

CERTIFICATE OF DEATH

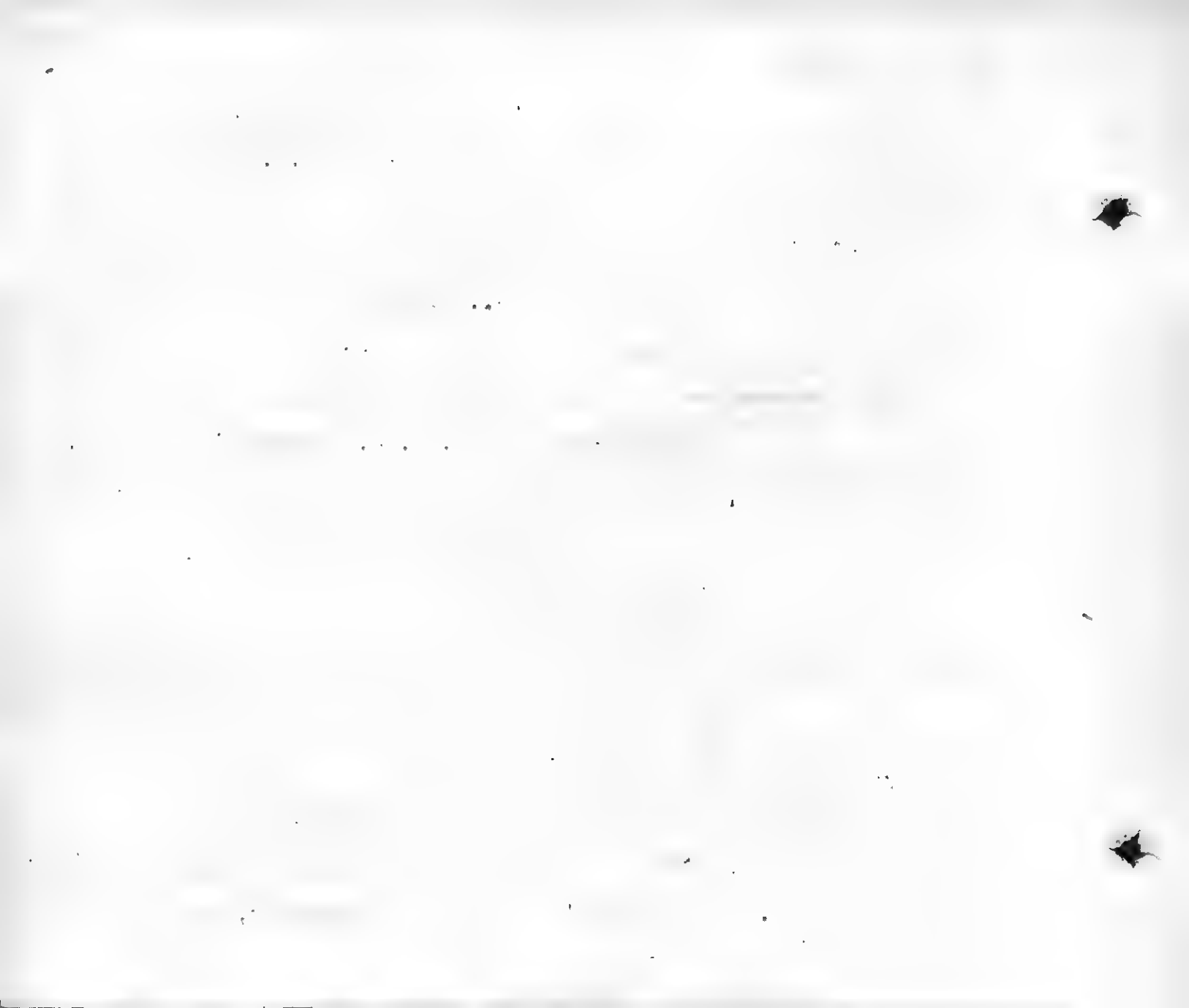
Reg. Dist. No.

07833

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Delaware b. COUNTY New Castle	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middletown R.D. 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		d. STREET ADDRESS 46X -	
3. NAME OF DECEASED (Type or print) First Middle Last XXXXXXXXXX Walter Coverdale		4. DATE OF DEATH Month Day Year July 25 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 23, 1878
9. AGE (In years last birthday) 82		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Coverdale Samuel Coverdale		14. MOTHER'S MAIDEN NAME Eliza Carpenter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 221-14-2396	
17. INFORMANT Mrs. W. S. George, Camden, Del.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) KILLX DUE TO UREMIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE CARDIOVASCULAR RENAL DISEASE (c) CHRONIC PROSTATITIS		INTERVAL BETWEEN ONSET AND DEATH 30 DAYS 3 years 5 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 1854 to July 25, 1961, that I last saw the deceased alive on July 25, 1961, and that death occurred at 8:11 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Henry T. Davis M.D.		ADDRESS (Street, city or town, state) CHESAPEAKE CITY	
PHYSICIAN'S NAME (Type) HENRY V. DAVIS MD		DATE SIGNED 7/26/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 28, 1961	
22c. NAME OF CEMETERY OR CREMATORY Barratt's Chapel		22d. LOCATION (City, town, or county) (State) Frederica, Delaware	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Joseph E. Nickles Elkton, Md.		24a. REC'D BY REGISTRAR DATE AUG 2 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

(I)

065



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7848

07839

1. PLACE OF DEATH e. COUNTY <u>Cecil</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>North East</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>East Cecil Avenue</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>North East</u> d. STREET ADDRESS <u>East Cecil Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>SARAH M. COYLE</u>		4. DATE OF DEATH Month <u>July</u> Day <u>16</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 13, 1874</u>
9. AGE (In years, last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> 11. IF UNDER 24 HRS Hours <u> </u> Mins. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>England</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Harry Worthington</u>		14. MOTHER'S MAIDEN NAME <u>John C. Coyle, North East, Maryland</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>John C. Coyle, North East, Maryland</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure - Valvular Heart Disease</u> + 42 X Conditions, if any, which gave rise to immediate cause (b) <u>Cardio- Vascular Renal Disease</u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Arthritis - Spinal</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 12, 1961, to July 16, 1961, that (I) (we) last saw the deceased alive on July 13, 1961, and that death occurred at 11 M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Arthur Cantwell</u>		22b. DATE SIGNED <u>7/18/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>H. Arthur Cantwell M.D.</u>		22d. ADDRESS <u>North East, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 19, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Immaculate Conception Cemetery, Elkton, Maryland</u>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Nicks, Elkton, Md.</u>		25a. REGISTERED BY REGISTRAR <u>Aug 1 1961</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>		25c. REGISTRAR'S SIGNATURE	

1
FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
1849 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07840

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>New Jersey</u> b. COUNTY <u>Salem</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN 1b <u>3 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pennsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Union Hospital of Cecil County</u>			d. STREET ADDRESS <u>5th & Castle Heights</u>		
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>A.</u> Last <u>Dalbrow</u>			4. DATE OF DEATH Month <u>July</u> Day <u>27</u> Year <u>1961</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-29-24</u>	9. AGE (in years last birthday) <u>36</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction Work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Paper Hanger</u>		11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>	
13. FATHER'S NAME <u>Stillwell Dalbrow</u>			14. MOTHER'S MAIDEN NAME <u>Christine Johnson</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes</u> <u>World War II</u>		16. SOCIAL SECURITY NO. <u>143-14-2943</u>		17. INFORMANT <u>Mrs. Harry Dalbrow</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u> </u> (c) <u> </u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Dr. R. C. Dodson</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>7-27-61</u>	
EXAMINER'S NAME (Type) <u>Dr. R. C. Dodson</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>7-27-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LAWN SIDE CEMETERY</u>	
23. FUNERAL DIRECTOR <u>PIPPIN FUNERAL HOME</u>		ADDRESS <u>Elkton</u>		24a. REC'D BY REGISTRAR <u>JUL 31 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Clint S. Thomas</u>	



1
FOR STATE
HEALTH DEPT.

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please indicate the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form DM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME
5M 9/60

361 STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7850 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07841

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Del. b. COUNTY NewCastle		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hollywood Beach			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wilmington		
c. LENGTH OF STAY IN 1b 48hrs.			d. STREET ADDRESS 1113 W. Third		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					
3. NAME OF DECEASED (Type or print) First John Middle Albert Last Dillman, Sr.			4. DATE OF DEATH Month 7 Day 28 Year 1961		
5. SEX M	6. COLOR OR RACE M	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 6, 1898	9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Welder		10b. KIND OF BUSINESS OR INDUSTRY Welding con.		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Samuel Dillman		
14. MOTHER'S MAIDEN NAME H. Scarborough			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		
16. SOCIAL SECURITY NO. 221-10-9138			17. INFORMANT Mrs. John A. Dillman Address Wilmington, Del. 1112 W. Third St.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dissecting Aneurysm of aorta arch 451X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Wilmington	(County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE R.C. Dodson		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7-29-61	
EXAMINER'S NAME (Type) R.C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Entombment		22b. DATE THEREOF 8/1/61		22c. NAME OF CEMETERY OR CREMATORY Gracelawn Abbey	
22d. LOCATION (City, town, or country) Farnhurst, Delaware		23. REC'D BY REGISTRAR AUG 4 '61			
23. FUNERAL DIRECTOR Albert J. McCrery		24b. REGISTRAR'S SIGNATURE Arthur S. Hines			
ADDRESS Wilmington, Delaware		DATE			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

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15M 9/60

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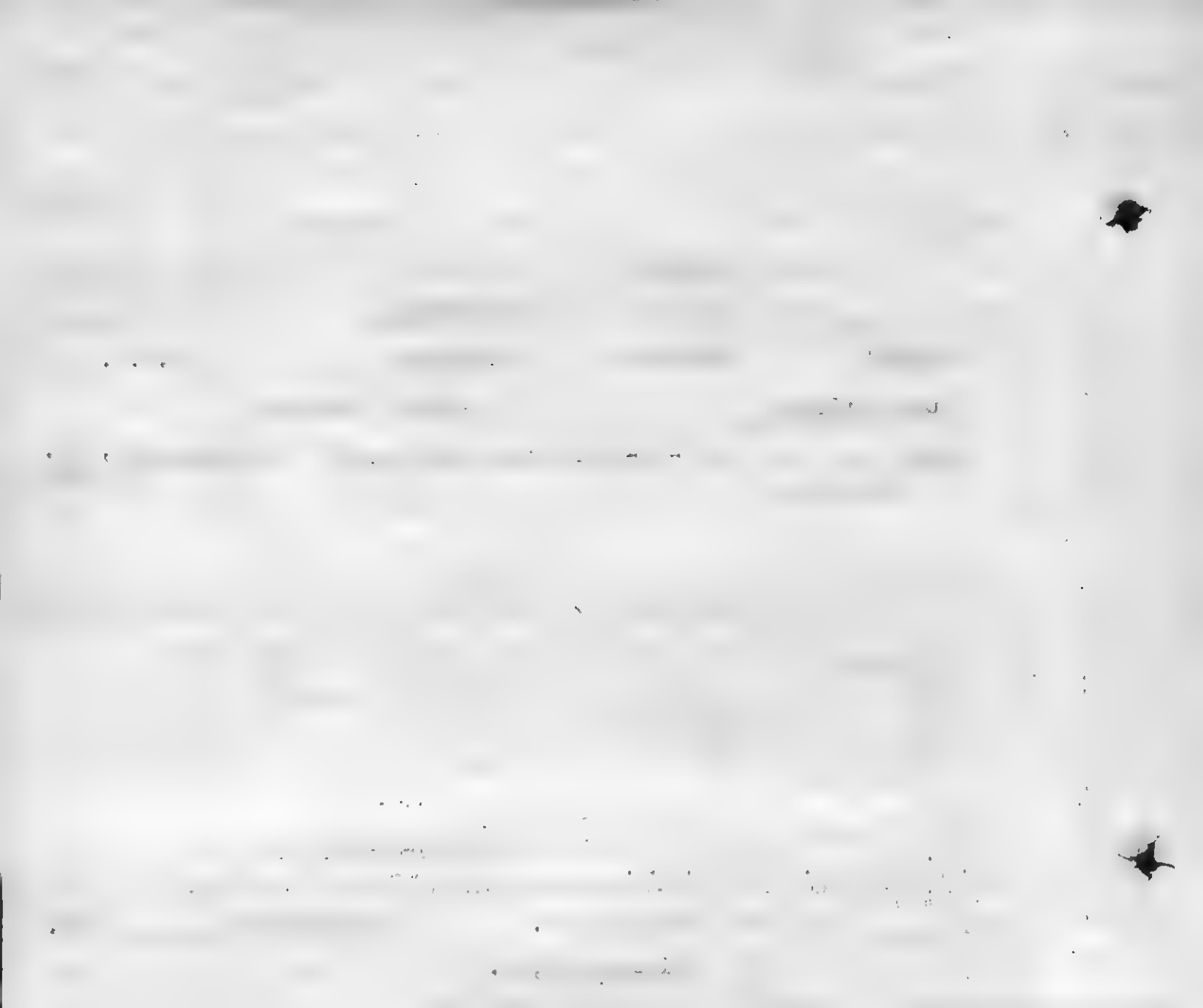
MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Cecil		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 38yrs.2mo.11days		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Pennsylvania		b. COUNTY Olanta	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS R.D. #1		4. DATE OF DEATH Month July		Day 5	
3. NAME OF DECEASED (Type or print) WALTER S. ENGLISH		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-15-86	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		9. AGE (In years last birthday) 75		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Fraffius English		14. MOTHER'S MAIDEN NAME Elizabeth Woodling		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW-I		16. SOCIAL SECURITY NO. Not available		17. INFORMANT Hospital Records, VAH, Perry Point, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Arrhythmia ventricular DUE TO (c) Arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH 5-15 min		unknown		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Arteriosclerosis generalized		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Hour a.m. p.m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that XXXXXXXXXXXX attended the deceased from April 24, 1923 , to July 5, 1961 and that death occurred at 11:20pm from the causes and on the date stated above.		22a. SIGNATURE A.L. Mooney		M.D. A.L. MOONEY		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 7-6-61	
22c. PHYSICIAN'S NAME (Type) A.L. MOONEY		23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL 7/7/1961		23b. DATE THEREOF 7/7/1961		23c. NAME OF CEMETERY OR CREMATORY Fairview		23d. LOCATION (City, town or county) (State) Clearfield County, Pa.	
24. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md.		25a. REC'D BY REGISTRAR 11-11-61		25b. REGISTRAR'S SIGNATURE William S. Kline					



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
7853 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
C7844									
1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS				
<u>North East River</u>					<u>Port Deposit Road</u>				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
<u>PAUL ESTEL FULLER</u>					<u>July 23, 1961</u>				
5. SEX <u>Male</u>					6. COLOR OR RACE <u>White</u>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>					8. DATE OF BIRTH <u>8/19/1909</u>				
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. AGE (In years last birthday) <u>51</u> yrs.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY				
<u>Laborer</u>					<u>Saw-Mill</u>				
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
<u>John Fuller</u>					<u>Julia Meadows</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO.				
<u>no</u>					<u>177-10-9691</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					19. WAS AUTOPSY PERFORMED?				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u>					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
929.8 DUE TO					INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
<u>Acute alcoholism</u>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
					<u>Found drowned (was swimming)</u>				
20c. TIME OF INJURY Month, Day, Year					20d. INJURY OCCURRED				
<u>4:35 p.m. 7/23/61</u>					<u>While at work</u>				
					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
					<u>North East River</u>				
					20f. (City or town) (County) (State)				
					<u>Cecil Md.</u>				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE					CHIEF MEDICAL EXAMINER				
<u>Peter W. Rieckert, M.D.</u>					<u>Associate Pathologist</u>				
EXAMINER'S NAME (Type)					DATE SIGNED				
					<u>7/24/61</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify)					22b. DATE THEREOF				
<u>Burial</u>					<u>7/27/1961</u>				
22c. NAME OF CEMETERY OR CREMATORY					22d. LOCATION (City, town, or country) (State)				
<u>Hopewell Cem.</u>					<u>Port Deposit Md.</u>				
22f. FUNERAL DIRECTOR					24a. REC'D BY REGISTRAR				
<u>Corron E. M. Mullen</u>					<u>July 27 '61</u>				
ADDRESS					24b. REGISTRAR'S SIGNATURE				
<u>Rising Sun, Md.</u>					<u>Charles S. Hearn</u>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Physicians may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7854

07845

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake City</u> c. LENGTH OF STAY IN It <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Morgan Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Chesapeake City</u> d. STREET ADDRESS <u>Box 217, R. D 1</u>		3. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>EDWIN RUTHVIN GILL</u>		4. DATE OF DEATH Month <u>July</u> Day <u>5</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>July 18, 1863</u>		9. AGE (in years last birthday) <u>92</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House Painting</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Bangor, Maine</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>John Alexander Gill</u>		14. MOTHER'S MAIDEN NAME <u>Matha Ellison</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. A. Hallier Johnson, Chesapeake City</u> Address <u>R. D. 1</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>OLD AGE</u> DUE TO (c) <u> </u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u> Month <u> </u> Day <u> </u> Year <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>					
21. I certify that (I) (the physician) attended the deceased from June 15, 1961, to July 5, 1961, that (I) (we) last saw the deceased alive on July 5, 1961, and that death occurred at 8 P.M. from the causes and on the date stated above.					
22a. SIGNATURE <u>Henry V. Davis MD</u>		22b. DATE SIGNED <u>7/6/61</u>		22c. PHYSICIAN'S NAME (Type) <u>HENRY V. DAVIS MD</u>	
22d. ADDRESS <u>CHESAPEAKE CITY MD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/10/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Pine Hill Cemetery</u>	
23d. LOCATION (City, town or county) <u>Dover, New Hampshire</u>		(State) <u> </u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Nickerson</u>		24b. ADDRESS <u>Baltimore, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 18 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Howard</u>					



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07846

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Perry Point</u> c. LENGTH OF STAY in lb <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Veterans Administration Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Perry Point</u> d. STREET ADDRESS <u>1173 Avenue D.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>DAVID MARKLEY GORDON</u> First Middle Last 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Refrigeration Mechanic</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>US Govt.</u> 13. FATHER'S NAME <u>John B. Gordon</u> 14. MOTHER'S MAIDEN NAME <u>Mary Macklem</u>		6. DATE OF DEATH <u>July 6 1961</u> Month Day Year 9. AGE (In years last birthday) <u>64</u> IF UNDER 1 YEAR Months Days Hours Min. 11. BIRTHPLACE (State or foreign country) <u>Wilmington, Delaware</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW-I</u> 16. SOCIAL SECURITY NO. <u>315-03-7382</u> 17. INFORMANT <u>Mrs. D. M. Gordon</u> Address <u>Perry Point, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1. Ventricular fibrillation.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>2. Arteriosclerotic heart disease.</u> DUE TO (c) <u>Unknown.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <u>Interval between onset and death 5-10 min.</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE <u>R. C. DODSON</u> EXAMINER'S NAME (Type)		DATE SIGNED <u>7/6/61</u> Address (Street, city, town, or county) <u>Rising Sun, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 22b. DATE THEREOF <u>7-9-1961</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Northeast Meth. Cem.</u> 22d. LOCATION (City, town, or county) <u>Northeast, Md. Cecil Co.</u>		24a. REC'D BY REGISTRAR <u>Jul 11 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
23. FUNERAL DIRECTOR <u>Mitchell Funeral Home, Havre de Grace, Md.</u> Address			

sterile

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7856

CERTIFICATE OF DEATH

Reg. Dist. No. 07847

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit, Rural		c. LENGTH OF STAY IN 1b 58 yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit, Rural		d. STREET ADDRESS Jackson Park Rd.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Jackson Park Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary Jane StClair First Middle Last		4. DATE OF DEATH July Month Day Year 20 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 27, 1883
9. AGE (In years and birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Keeper		10b. KIND OF BUSINESS OR INDUSTRY U S N Base	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William J. StClair		14. MOTHER'S MAIDEN NAME Anna R. Morrison	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-14-2094	
17. INFORMANT Clifton Jackson, Port Deposit, Md.		Address R D	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage, Left Side ix DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Cerebro-sclerosis (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 60 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 16, 1961 to July 20, 1961 , that I last saw the deceased alive on July 20, 1961 , and that death occurred at 7:15 PM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED July 21, 1961	
ACTUAL SIGNATURE Clarence I. Benson M.D.			
PHYSICIAN'S NAME (Type) Clarence I. Benson, M.D.		Port Deposit, Md.	
22a. BURIAL, CREMATION, REINTERMENT (Specify) Burial		22b. DATE THEREOF 7-23-1961	
22c. NAME OF CEMETERY OR CREMATORY Hopewell Cemetery		22d. LOCATION (City, town, or county) (State) Port Deposit, Md. Rural	
23. FUNERAL DIRECTOR'S SIGNATURE Veeva Patterson & Son		ADDRESS Perryville, Md.	
24a. REC'D BY REGISTRAR JUL 25 '61		24b. REGISTRAR'S SIGNATURE Arthur S. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

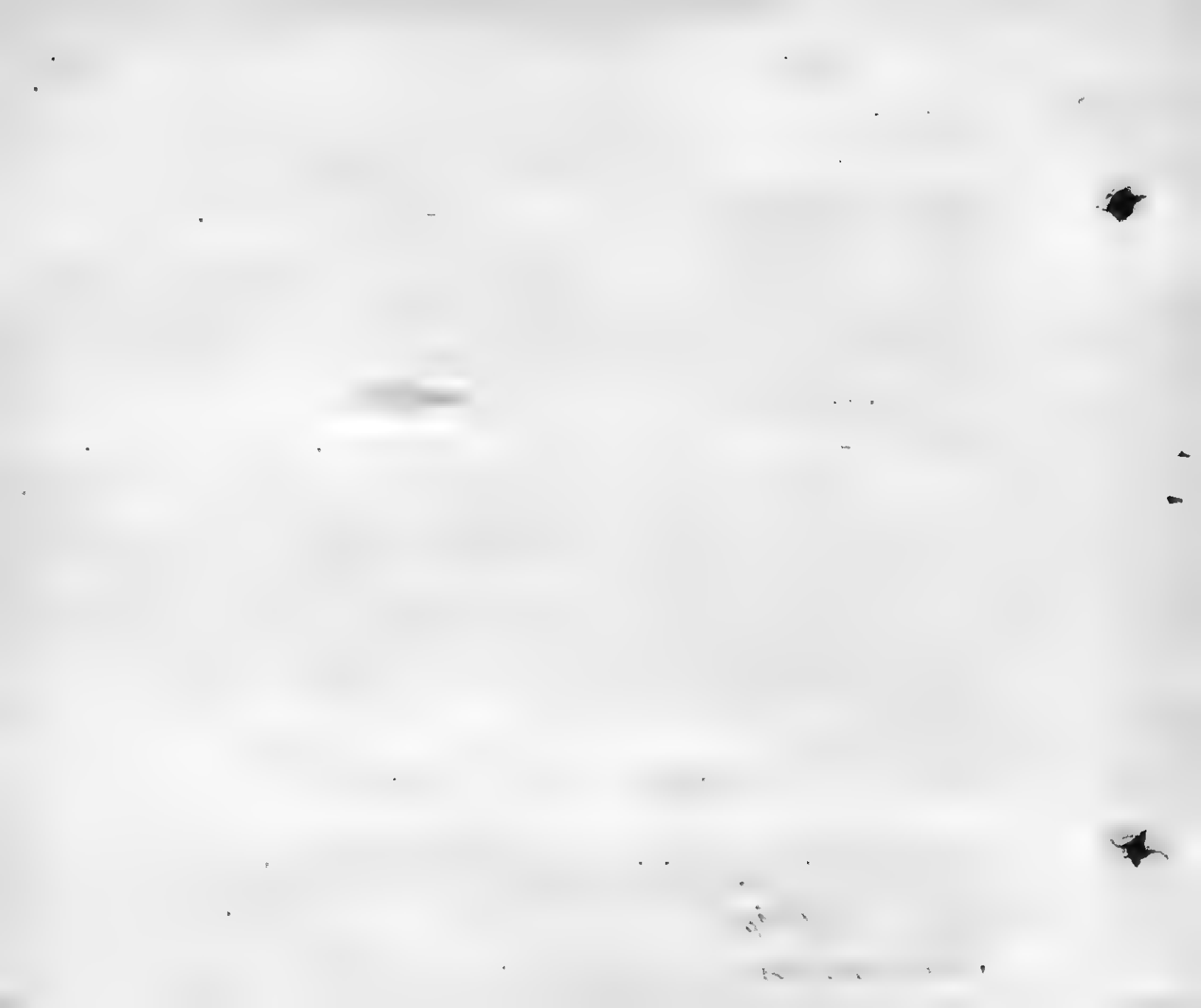
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7857

07848

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN 1b 12yrs6mos8days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital			2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE District of Columbia f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 233 - 34th Street, N.E. g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First OLIVER Middle G. Last JACKSON			4. DATE OF DEATH Month July Day 13 Year 1961									
5. SEX Male <input checked="" type="checkbox"/> Female <input type="checkbox"/>			6. COLOR OR RACE White <input type="checkbox"/> Negro <input checked="" type="checkbox"/>									
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			8. DATE OF BIRTH June 6, 1898									
9. AGE (In years last birthday) 63 yrs. <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months Days</td> <td>Hours Min.</td> </tr> </table>			IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months Days	Hours Min.						
IF UNDER 1 YEAR	IF UNDER 24 HRS.											
Months Days	Hours Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY Unknown									
11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA									
13. FATHER'S NAME LLOYD T. JACKSON			14. MOTHER'S MAIDEN NAME ALICE DIGGS									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) YES WW-I			16. SOCIAL SECURITY NO. UNKNOWN									
17. INFORMANT Hospital Records, VAH., Perry Point, Md.			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) <table border="1"> <tr> <td colspan="2"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARRHYTHMIA, ventricular 410 </td> <td rowspan="3"> INTERVAL BETWEEN ONSET AND DEATH 15-30 min. Unknown </td> </tr> <tr> <td colspan="2"> DUE TO ARTERIOSCLEROTIC HEART DISEASE (b) </td> </tr> <tr> <td colspan="2"> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) </td> </tr> </table>			PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARRHYTHMIA, ventricular 410		INTERVAL BETWEEN ONSET AND DEATH 15-30 min. Unknown	DUE TO ARTERIOSCLEROTIC HEART DISEASE (b)		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARRHYTHMIA, ventricular 410		INTERVAL BETWEEN ONSET AND DEATH 15-30 min. Unknown										
DUE TO ARTERIOSCLEROTIC HEART DISEASE (b)												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)												
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER!) <table border="1"> <tr> <td colspan="2"> 20c. TIME OF INJURY Hour e.m. Month VA Day 19 </td> <td colspan="2"> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> </td> <td colspan="2"> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) </td> </tr> </table>						20c. TIME OF INJURY Hour e.m. Month VA Day 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		
20c. TIME OF INJURY Hour e.m. Month VA Day 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)								
20f. (City or town) (County) (State)												
21. I certify that A. L. MOONEY attended the deceased from January 5, 1949 to July 13, 1961 , and that death occurred at 1:20AM from the causes and on the date stated above. <table border="1"> <tr> <td colspan="2"> 22a. SIGNATURE A. L. Mooney </td> <td colspan="2"> 22b. DATE SIGNED July 13, 1961 </td> </tr> </table>						22a. SIGNATURE A. L. Mooney		22b. DATE SIGNED July 13, 1961				
22a. SIGNATURE A. L. Mooney		22b. DATE SIGNED July 13, 1961										
22c. PHYSICIAN'S NAME (Type) A. L. MOONEY, M.D. Asst. Clinical Pathologist												
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE THEREOF 7/18/1961		23c. NAME OF CEMETERY OR CREMATORY Arlington National								
23d. LOCATION (City, town or county) Ft Myer, Va.		(State)										
24. FUNERAL DIRECTOR'S SIGNATURE PEPPERINGTON & SON			ADDRESS Havre De Grace, Md.									
25a. REC'D BY REGISTRAR DATE JUL 19 1961			25b. REGISTRAR'S SIGNATURE Arthur S. Harris									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician. To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers on pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7858

07849

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Point</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hill</u>	
c. LENGTH OF STAY IN 1b <u>49 days</u>		d. STREET ADDRESS <u>Box 57</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Veterans Administration Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>Unknown</u>	
3. NAME OF DECEASED (Type or print) <u>OKEY Layton LEWIS</u>		4. DATE OF DEATH <u>July 24 19 61</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 17, 1917</u>
9. AGE (in years last birthday) <u>44</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter's Helper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>R.R. -Carpentering W. Va.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Romey Lewis (deceased)</u>		14. MOTHER'S MAIDEN NAME <u>Hallie McCoy</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW-II</u>		16. SOCIAL SECURITY NO. <u>218-18-8548</u>	
17. INFORMANT <u>Hospital Records, VAH, Perry Point, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Bronchopneumonia associated with debilitation</u> 722.0 DUE TO <u>Pericarditis & Pleuritis</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <u>Rheumatoid arthritis severe</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>4-7 days</u> <u>6-8 weeks</u> <u>Years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>VA 19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u>A. L. Mooney</u> attended the deceased from <u>June 5</u>, 19 <u>61</u> , to <u>July 24</u>, 19 <u>61</u> and that death occurred <u>3:45am</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>A. L. MOONEY</u>		22b. DATE SIGNED <u>7-24-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>A. L. MOONEY</u>		22d. ADDRESS <u>Asst. Clinical Pathologist, VAH, Perry Point, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/26/1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Friendship</u>		23d. LOCATION (City, town or county) (State) <u>Fallston, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>KURTZ FUNERAL HOME, Jarrettsville, Md.</u>		25a. REC'D BY REGISTRAR <u>JUL 26 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

CERTIFICATE OF DEATH

Reg. Dist. No. **07850**

7859

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit			c. LENGTH OF STAY IN 1b Life		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Center St.			d. STREET ADDRESS Center St.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Rosie Middle L. Last Mason			4. DATE OF DEATH Month July Day 8 Year 19 61		
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 12, 1883		9. AGE (In years last birthday) 78 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME James Jones			14. MOTHER'S MAIDEN NAME Ellen Anby		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Virginia Mason, Port Deposit, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Uterus - DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH 4 yrs					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Hypertension - Cor. Arteriosclerosis -					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1961 to July 7, 1961 , that I last saw the deceased alive on July 7, 1961 , and that death occurred at 5:30 A.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE Clarence I. Benson M.D.		ADDRESS (Street, city or town, state) Port Deposit, Md.		DATE SIGNED July 9, 1961	
PHYSICIAN'S NAME (Type) Clarence I. Benson					
22a. BURIAL, CREMATION, or other disposition (Specify) Burial		22b. DATE THEREOF 7-11-1961		22c. NAME OF CEMETERY OR CREMATORY Cokesbury Cemetery	
22d. LOCATION (City, town, or county) (State) Port Deposit, Md. Rural					
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Patterson & Son		ADDRESS Perryville, Md.		24a. REC'D BY REGISTRAR DATE JUL 11 '61	
24b. REGISTRAR'S SIGNATURE Clifton S. Kiser					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7850 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07851

1. PLACE OF DEATH a. COUNTY Cecil				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hacks Point				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton R.F.D.			
c. LENGTH OF STAY in 1b visiting				d. STREET ADDRESS			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Dora M. McCommons				4. DATE OF DEATH Month Day Year 7 9 19 61			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-27-1945	
9. AGE (In years last birthday) 16 yrs.		10. IF UNDER 1 YEAR Months Days 16		11. IF UNDER 24 HRS. Hours Min. 16		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Girl				10b. KIND OF BUSINESS OR INDUSTRY Student			
11. BIRTHPLACE (State or foreign country) Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME A.P. McCommons				14. MOTHER'S MAIDEN NAME Ethel Jackson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no				16. SOCIAL SECURITY NO. no			
17. INFORMANT Robert Feard, Chesapeake City, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Drowned 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Swimming and went into deep water DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Swimming and went into deep water							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour Min. p.m. 6 7 9 61		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Long Point		20f. (City or town) (County) (State) Hacks Point Cecil Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE R.C. Dodson				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) R.C. Dodson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 7/12/1961			
22c. NAME OF CEMETERY OR CREMATORY Cherry Hill Cemetery				22d. LOCATION (City, town, or country) (State) Cherry Hill, Maryland			
23. FUNERAL DIRECTOR PIPI IN FUNERAL HOME				24. REC'D BY REGISTRAR Jul 19 61			
24b. REGISTRAR'S SIGNATURE Charles E. Kraus				DATE SIGNED 7-20-61			

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7861

CERTIFICATE OF DEATH

Reg. Dist. No.

07852

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville, Rural		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Aikin Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jane Middle Watson Last McGuire		4. DATE OF DEATH Month July Day 11 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-3-1882
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months 7 Days 11 Hours 11 Min.	11. IF UNDER 24 HRS. Hours 11 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Henry Watson	
14. MOTHER'S MAIDEN NAME Laura Patterson		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO None		17. INFORMANT Howard McGuire, Liberty Grove, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis 4. DUE TO Mild diabetic mellitus Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (b) Arteriosclerosis - General DUE TO (c) 10 yrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 3, 1958 to July 11, 1961 , that I last saw the deceased alive on July 10, 1961 , and that death occurred at 9:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE G.H. Richards Jr.		ADDRESS (Street, city or town, state) Port Deposit, Md.	
DATE SIGNED 7/11/61		DATE SIGNED	
22a. BURIAL, CREMATION, REINTERMENT (Specify) Burial		22b. DATE THEREOF 7-14-1961	
22c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery		22d. LOCATION (City, town, or county) (State) Port Deposit, Md. Rural	
23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Son		ADDRESS Perryville, Md.	
24a. REC'D BY REGISTRAR DATE JUL 13 '61		24b. REGISTRAR'S SIGNATURE William S. Kenna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 1 may be retained by the hospital or attending physician. Part 2 may be retained by the funeral director. Part 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7862
CERTIFICATE OF DEATH
07853

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY in lb 23 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VA Hospital		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Virginia b. COUNTY None c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria d. STREET ADDRESS 1708 A Common Wealth Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Samuel A. Moss Jr.		4. DATE OF DEATH Month 7-2-61 Day 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-6-17
9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months 8 Days 26	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper		10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (County & State, or foreign country) Prince William - Va.
12. CITIZEN OF WHAT COUNTRY U. S. A.		13. FATHER'S NAME Samuel A. Moss Sr.	
14. MOTHER'S MAIDEN NAME Lottie Perkins		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW II	
16. SOCIAL SECURITY NO. Unk.		17. INFORMANT VA Records - VAH Perry Point, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis due to extravasated contents DUE TO of viscera Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Rupture of duodenal ulcer DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 		INTERVAL BETWEEN ONSET AND DEATH 11 days unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (If at this hospital) attended the deceased from 6-9-61 to 7-2-61 , 19 61 and that death occurred at 1:00 from the causes and on the date stated above.		22a. SIGNATURE A. L. Mooney M.D. 22c. PHYSICIAN'S NAME (Type) A. L. MOONEY, Asst. Clinical Pathologist, V.A. Hospital, Perry Point, Md	
22b. DATE SIGNED 7-3-61		22d. ADDRESS Arlington, Va.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 7/5/1961	
23c. NAME OF CEMETERY OR CREMATORY Arlington		23d. LOCATION (City, town or county) (State) Arlington, Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havee de Grace, Md.		25. REC'D BY REGISTRAR 7 '61	
25b. REGISTRAR'S SIGNATURE William S. Hume			

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7863

CERTIFICATE OF DEATH

C7854

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>236 West High Street</u>		d. STREET ADDRESS <u>236 West High Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Lacy</u> Middle <u>May</u> Last <u>Nickle</u>		4. DATE OF DEATH Month <u>July</u> Day <u>3</u> Year <u>1961</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 10, 1878</u>
9. AGE (In years lost birthday) <u>82</u> yrs		10. UNDER 1 YEAR IF UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>No Info.</u>		14. MOTHER'S MAIDEN NAME <u>No Info.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Ward B. Nickle</u>		Address <u>Elkton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis, generalized</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Years</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov</u> , 19 <u>60</u> , to <u>July 3</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>July 3</u> , 19 <u>61</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>103 Singlerly Ave</u> DATE SIGNED _____ ACTUAL SIGNATURE <u>Tillman D. Johnson</u> M.D. _____ PHYSICIAN'S NAME (Type) <u>Tillman D. Johnson</u> <u>Elkton</u> <u>Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/7/1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hopewell Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hopewell, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>PIPPIN FUNERAL HOME</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 10 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Anthony L. Kneass</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7864 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07855

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN b Less than 24 hrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Whiteford d. STREET ADDRESS Main	
3. NAME OF DECEASED (Type or print) OLIVER G. PARTHREE First Middle Last 4. DATE OF DEATH July 14 1961 Month Day Year		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 4-1-06 9. AGE (In years last birthday) 55 yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver 10b. KIND OF BUSINESS OR INDUSTRY Trucker		11. BIRTHPLACE (State or foreign country) Delta, Pennsylvania 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John M. Parthree		14. MOTHER'S M.A.DEN NAME Cecelia Downey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW-II		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Hospital Records, VAH, Perry Point, Md. Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. Hemorrhage, subdural, right. (b) 2. Fractures of the calvarium, multiple. (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell down flight of stairs, approximately 10 steps.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 3:30 xxx July 13 1961		20d. INJURY OCCURRED <input checked="" type="checkbox"/> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) Whiteford (County) Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>R. C. Dodson</i> EXAMINER'S NAME (Type) R. C. DODSON		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Rising Sun, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-17-1961	
22c. NAME OF CEMETERY OR CREMATORY Mt. Nebo		22d. LOCATION (City, town, or country) (State) Delta, Pa.	
23. FUNERAL DIRECTOR Harkins Funeral Home, Delta, Pa. Address		24a. REC'D BY REGISTRAR DATE JUL 18 '61	
24b. REGISTRAR'S SIGNATURE <i>William S. Kneass</i>		DATE SIGNED 7-14-61	

1911

1911

1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7865

CERTIFICATE OF DEATH

Reg. Dist. No. 07856

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton Rural</u>		c. LENGTH OF STAY IN 1b <u>6 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton Rural</u>	
		d. STREET ADDRESS <u>1</u>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mattie</u> Middle <u>Adams</u> Last <u>Pugh</u>		4. DATE OF DEATH Month <u>July</u> Day <u>12</u> Year <u>19 61</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-28-1895</u>
9. AGE (In years last birthday) <u>66</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jackson Adams</u>		14. MOTHER'S MAIDEN NAME <u>Nancy Denny</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>no</u>	
INFORMANT <u>Roger Pugh</u>		Address <u>Elkton Rd Maryland</u>	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sarcoma of the chest wall with</u> <u>1977</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>pulmonary metastases</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>generalized arteriosclerosis and malnutrition</u> 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July 9</u> , 1961, to <u>July 12</u> , 1961 that I last saw the deceased alive on <u>July 11</u> , 1961, and that death occurred at <u>4:45 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>233 E. Main Street</u> DATE SIGNED <u>7/12/61</u> ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>Elkton Maryland</u> PHYSICIAN'S NAME (Type) <u>S. Ralph Andrews, Jr., M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 15, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lansing Ashe Co., N.C.</u>		22d. LOCATION (City, town or county) (State) <u>Lansing Ashe Co., N.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Grant</u>		24a. REC'D BY REGISTRAR <u>JUL 17 '61</u>	
ADDRESS <u>North East Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneass</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers on pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7866

07857

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fredricktown Home c. LENGTH OF STAY IN 1b 1 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fredricktown d. STREET ADDRESS X	
3. NAME OF DECEASED (Type or print) First Howard Middle Reese Last Reese		4. DATE OF DEATH Month July Day 13 Year 1961	
5. SEX Male		6. COLOR OR RACE Colored	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH January 30, 1899		9. AGE (In years) IF UNDER 1 YEAR, last birthday Months Days Hours Min. 62 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Labor		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (Country & State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Howard Reese Sr.		14. MOTHER'S M.A.D.E.N. NAME Annie Gaddys	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. Rosie Henry, Henderson, Md. R.D.1	
17. INFORMANT Rosie Henry, Henderson, Md. R.D.1		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 420.0 DUE TO Acute congestive failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute Bronchial asthma		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I, or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 12, 1961 to July 13, 1961 , that (I) (we) last saw the deceased alive on July 13, 1961 , and that death occurred at 3 PM , from the causes and on the date stated above.			
22a. SIGNATURE Wallace O. Branchain		22b. DATE SIGNED 14 July 61	
22c. PHYSICIAN'S NAME (Type) Wallace O. Branchain, M.D.		22d. ADDRESS Cecilton, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 16, 1961	
23c. NAME OF CEMETERY OR CREMATORY Cecilton Cemetery		23d. LOCATION (City, town or county) (State) Cecil Co; Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows, Mellington, Md.		25a. REC'D BY REGISTRAR JUL 18 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 07858

7867

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN 1b <u>1 Day</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Naomi S. Ross.</u>		4. DATE OF DEATH Month Day Year <u>7 24 1961</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 4 1912</u>
9. AGE (In years last birthday) <u>48</u> yrs		10. IF UNDER 1 YEAR: Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>House Work</u>	
11c. BIRTHPLACE (State or foreign country) <u>W.Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles M. Swartz</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Conley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>XXXXXXXX</u>		16. SOCIAL SECURITY NO <u>XXXXXXXX</u>	
17. INFORMANT <u>Pemberton J. Ross, Rd # 4, Elkton, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhagic Pericarditis</u> DUE TO <u>Pneumonectomy Of Right Lung</u> (b) <u>Carcinoma Of Lung</u> (c) <u>Carcinoma Of Lung</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 Days</u> <u>3 Months</u> <u>4 Months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/23/1961</u> to <u>7/24/1961</u> , that I last saw the deceased alive on <u>7/24/1961</u> , and that death occurred at <u>6:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>245 East High Street Elkton, Maryland</u> DATE SIGNED <u>7/26/61</u>			
ACTUAL SIGNATURE <u>James L. Johnson</u>		M.D. <u>James L. Johnson M. D.</u>	
PHYSICIAN'S NAME (Type) <u>James L. Johnson M. D.</u>		<u>Elkton, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/27/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Elkton Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Elkton, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Boock</u>		ADDRESS <u>Elkton, Md.</u>	
24a. REC'D BY REGISTRAR <u>JUL 31 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Robert L. Boock</u>	



7868

CERTIFICATE OF DEATH

Reg. Dist. No. 07859

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Elkton,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Devine Haven Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Kathryn H. Scarborough		4. DATE OF DEATH Month July Day 19 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 4, 1873
9. AGE (In years last birthday) 87 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Washington Hall	
14. MOTHER'S MAIDEN NAME Sarah Jane Steele		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO.		INFORMANT Address Stanley R. Scarborough, R. D. 3, Elkton	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4:20.0 DUE TO Bronchopneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive Heart Failure (c) A.H.D.		INTERVAL BETWEEN ONSET AND DEATH 1 week 1 year 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Nephrosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I of Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1953 to 7/9, 1961, that I last saw the deceased alive on 7/17, 1961, and that death occurred at 4:25 P.M. from the causes and on the date stated above			
ACTUAL SIGNATURE Peter Stavrakis, M.D.		DATE SIGNED 7/24/61	
PHYSICIAN'S NAME (Type) Peter Stavrakis, M.D.		154 W. Main St., Elkton, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 22, 1961	22c. NAME OF CEMETERY OR CREMATORY Cherry Hill Cemetery	22d. LOCATION (City, town, or county) Cecil County Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicke		24a. REC'D BY REGISTRAR DATE AUG 1 '61	
ADDRESS Elkton, Maryland		24b. REGISTRAR'S SIGNATURE Charles S. Finney	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7869

CERTIFICATE OF DEATH

Reg. Dist. No. 07860

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 5 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Bert Middle Sexton Last		4. DATE OF DEATH Month July Day 1 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 20, 1920
9. AGE (In years lost birthday) 40 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto. mechanic		10b. KIND OF BUSINESS OR INDUSTRY Automotive	11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Lester F Sexton	
14. MOTHER'S MAIDEN NAME Btta Weidner		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	
16. SOCIAL SECURITY NO. 232-28-8686		INFORMANT Mrs. Lillie R. Sexton Charlestown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Branchopneumonia Organism Undet</u> DUE TO (b) <u>And Myocardial Infarction</u> DUE TO (c) <u>And Acute Fibrinous Pericarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 6 days 10 days 8 days	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 26 1961</u> to <u>July 1, 1961</u> , that I last saw the deceased alive on <u>July 1, 1961</u> , and that death occurred at <u>11:45 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>July 5, 1961</u>			
ACTUAL SIGNATURE <u>Williford Eppes</u> M.D.		PHYSICIAN'S NAME (Type) <u>Williford Eppes</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-5-1961	
22c. NAME OF CEMETERY OR CREMATORY Harford Memorial Gardens		22d. LOCATION (City, town, or county) Harford County Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Grant</u> ADDRESS <u>Joseph R. Grant, North East, Md.</u>		24a. REC'D BY REGISTRAR DATE JUL 6 '61	
24b. REGISTRAR'S SIGNATURE <u>W. L. Turner</u>			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7870

07861

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Joppa	
c. LENGTH OF STAY in 1b 15 days		d. STREET ADDRESS Box 537	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> Unknown	
3. NAME OF DECEASED (Type or print) JOSEPH (NMI)		4. DATE OF DEATH July 11 1961	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-28-96	
9. AGE (in years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Stankie		14. MOTHER'S MAIDEN NAME Victoria (?)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW-I		16. SOCIAL SECURITY NO. 705-07-2384	
17. INFORMATION Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of stomach with metastasis DUE TO (b) 151x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (a) (the hospital) attended the deceased from June 26, 1961 to July 11, 1961 and that death occurred 11:15am from the causes and on the date stated above.			
22a. SIGNATURE B. Rothfeld		22b. DATE SIGNED 7-11-61	
22c. PHYSICIAN'S NAME (Type) B. ROTHFELD, Acting Chief, Medical Service, VAH, Perry Point, Md.		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 14, 1961	
23c. NAME OF CEMETERY OR CREMATORY St. Stephens		23d. LOCATION (City, town or county) (State) Bradshaw, Balto., Maryland	
24. FUNERAL HOME'S SIGNATURE Howard K. McComas & Son, Abingdon, Md.		25a. REC'D BY REGISTRAR DATE JUL 17 '61	
25b. REGISTRAR'S SIGNATURE William S. Thayer			

VR A15 (4)
15M 9/60

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07862

7871

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. NO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Cecil		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN b. Less than 24hrs		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 4914 E. Federal		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) ROBERT C. SUMMERS		First Middle Last		4. DATE OF DEATH July 21 1961		Month Day Year		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 7-14-28		9. AGE (In years last birthday) 33 yrs		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS. Hours Min							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (State or foreign country) Connecticut		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Carleton Summers		14. MOTHER'S MAIDEN NAME Evelyn Mealie		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW-II		16. SOCIAL SECURITY NO. 220-24 9030		17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. Bronchopneumonia, bilateral. DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) 2. Abdominal carcinomatosis, primary site unknown. DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a)																INTERVAL BETWEEN ONSET AND DEATH 7 days Unknown											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.																20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Rising Sun, Md.		(County)		(State)		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>													
21. ACTUAL SIGNATURE R. C. DODSON		21. EXAMINER'S NAME (Type) R. C. DODSON		21. DATE THEREOF 7-24-61		21. NAME OF CEMETERY OR CREMATORY Cheseco		21. LOCATION (City, town, or country) Baltimore, Md.		21. ADDRESS (Street, city, town, or county) Baltimore, Md.		21. DATE 7/21/61		21. REGISTRAR'S SIGNATURE Arthur S. Kruis													
22. BURIAL, CREMATION, REMOVAL (Specify) Burial																22. DATE THEREOF 7-24-61		22. NAME OF CEMETERY OR CREMATORY Cheseco		22. LOCATION (City, town, or country) Baltimore, Md.		22. ADDRESS (Street, city, town, or county) Baltimore, Md.		22. DATE 7/24/61		22. REGISTRAR'S SIGNATURE Arthur S. Kruis	
23. FUNERAL DIRECTOR Rosedale Funeral Home, 2411 Cheseco Ave.																24a. REC'D BY REGISTRAR Jul 24 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kruis									

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The death certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7872 CERTIFICATE OF DEATH 07863

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 7mo.13days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3Y01-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans administration Hospital				d. STREET ADDRESS 3914 Pinkney Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHARLES		First Middle Last LEWIS TOOR		4. DATE OF DEATH July 27 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-22-97	
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10b. KIND OF BUSINESS OR INDUSTRY Store		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Simon Toor (deceased)				14. MOTHER'S MAIDEN NAME Ida Sealfon (deceased)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-1		17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) Hypertensive cardio - vascular disease Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, generalized. Chronic Brain Syndrome						INTERVAL BETWEEN ONSET AND DEATH Unk.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from December 14, 1960 to July 27, 1961 and that death occurred at 2:58 PM on the causes and on the date stated above.							
22a. SIGNATURE Dmitri Allahverdi				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 7-27-61	
22c. PHYSICIAN'S NAME (Type) DMITRI ALLAHVERDI, M.D.				22d. ADDRESS V.A. Hospital, Perry Point, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 28/61		23c. NAME OF CEMETERY OR CREMATORY Beth Tfiloh		23d. LOCATION (City, town or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Sol Levenson & Bros. 6010 Reistertown Rd.,				25a. REC'D BY REGISTRAR AUG 1 1961		25b. REGISTRAR'S SIGNATURE Arthur S. Evans	

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Carlton S. Howard

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